

**APPLICATION / PERMIT TO TAKE GAME WITH A CROSSBOW**

The requested information is required under authority of Part 401, Act 451, P. A. 1994, as amended, to be considered for a permit.

A person who falsely obtains or unlawfully uses the permit herein authorized is guilty of a misdemeanor and subject to imprisonment for up to 90 days, or a fine of not less than \$200.00 nor more than \$1,000.00, or both, and the cost of prosecution.

This permit is not valid until signed by the DNR Director's authorized representative. Once issued, the permit must be carried by the permittee while attempting to take game using a crossbow during the open season for that game. The permittee must also have a license to take that game. Read the additional information and requirements on the reverse side or page 2 of this application.

Please Note: Permits issued to persons eligible because of a progressive neuromuscular disease or a central nervous disorder shall be issued for 2 years and are renewable only upon reapplication. All other crossbow permits are valid indefinitely unless revoked.

SECTION I – APPLICANT INFORMATION: *Please type or print all information other than signature.*

NAME OF APPLICANT		MICHIGAN DRIVER'S LICENSE OR I.D. NUMBER - - - -	
STREET ADDRESS		MICHIGAN DNR SPORTCARD # (If no Michigan Driver's License or I.D.) - - - -	
CITY	STATE	ZIP CODE	APPLICANT'S DATE OF BIRTH - -
		DAYTIME AREA CODE & TELEPHONE NO () -	
NAME OF PHYSICIAN		PHYSICIAN'S DAYTIME AREA CODE & TELEPHONE NUMBER () -	
STREET ADDRESS		CITY	STATE ZIP CODE
<i>I certify that the above information is true.</i>			
Applicant's Signature		Date	

Note: If you are an amputee or have a spinal cord injury as identified below, complete only Section I and II. **If you are not an amputee or do not have a spinal cord injury you must have a physical therapy evaluation and Section III completed by a licensed physical therapist.**

SECTION II – PHYSICIAN DIAGNOSIS/CERTIFICATION: To be completed by the above named physician. **If the applicant has an amputation or spinal cord injury, check the appropriate box, if not a **Physical Therapist Evaluation** must be completed. **Section III must be completed by a Physical Therapist.**** Objective test findings are to be certified by the Physician named above **after** the evaluation.

Does the applicant have either of the following disabilities?

- ☐ Yes ☐ No **Amputations** involving 4 fingers at the proximal interphalangeal joint, wrist, elbow, and shoulder.
- ☐ Yes ☐ No **Spinal Cord Injury** above the level of C-8, resulting in permanent disability to the lower extremities, leaving the applicant permanently non-ambulatory
- ☐ Yes ☐ No **PHYSICIAN'S CERTIFICATION OF PHYSICAL THERAPIST'S FINDINGS**

I have reviewed and confirm the objective test findings below of the qualified physical therapist. The applicant hereon named has at least 80% permanent disability, in combination or an individual impairment, of a hand, elbow or shoulder due to one or more of the criteria below.

Physician's Signature

Date

SECTION III – PHYSICAL THERAPIST EVALUATION: *Please complete all applicable information below. **The disabilities listed below require an evaluation by a Physical Therapist and certification of the objective test findings by a Physician. See Page 2 for Disability Criteria and Required Test Standards.***

PHYSICAL THERAPIST'S NAME (PRINT/TYPE)		PHYSICAL THERAPIST'S LICENSE NUMBER.
<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Peripheral Nerve Involvement	<input type="checkbox"/> Coordination Assessment
<input type="checkbox"/> Impaired Range Of Motion	<input type="checkbox"/> Unilateral Hand Weakness Disability	
Both of the questions below must be answered.		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is applicant's disability the result of progressive neuromuscular disease or a central nervous disorder?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does applicant qualify for a Crossbow Permit? (80% Permanent Disability)	
Physical Therapist's Signature		Date

Please mail this completed application to:

**CROSSBOW PROGRAM
CUSTOMER SYSTEMS
MICHIGAN DEPARTMENT OF NATURAL RESOURCES
PO BOX 30181
LANSING MI 48909-7681**

FOR MICHIGAN DEPARTMENT OF NATURAL RESOURCES USE ONLY

PERMIT ISSUE DATE	PERMIT EXPIRATION DATE
BY: (For Director, Michigan Department of Natural Resources)	

INFORMATION AND REQUIREMENTS FOR APPLICATION / PERMIT TO TAKE GAME WITH A CROSSBOW

DEFINITIONS

"Crossbow": A weapon consisting of a bow mounted transversely on a stock or frame and designed to fire an arrow, bolt, or quarrel by the release of a bow string controlled by a mechanical or electric trigger with a working safety and a draw weight of 100 pounds or greater.

"Physical Therapist": A person licensed to engage in the practice of physical therapy under Article 15 of the public health code, 1978 PA 368.

"Physician": A person licensed by the State to practice medicine or osteopathic medicine and surgery under Article 15 of the public health code, 1978 PA 368.

REQUIREMENTS

Arrows, Bolts, and Quarrels used for taking deer, bear, elk, and turkey with a crossbow must be at least 14 inches in length and have a broadhead hunting type of point not less than 7/8 inch wide.

LIABILITY. Permittee hereby releases, waives, discharges and covenants not to sue the State of Michigan, its departments, officers, employees and agents, from any and all liability to Permittee, its officers, employees and agents, for all losses, injury, death or damage, and any claims or demands thereto, on account of injury to person or property, or resulting in death of Permittee, its officers, employees or agents, in reference to the activities authorized by this permit.

INDEMNIFICATION. Permittee hereby covenants and agrees to indemnify and save harmless, the State of Michigan, its departments, officers, employees and agents, from any and all claims and demands, for all loss, injury, death or damage, that any person or entity may have or make, in any manner, arising out of any occurrence related to (1) issuance of this permit; (2) the activities authorized by this permit; and (3) the use or occupancy of the premises which are the subject of this permit by the Permittee, its employees, contractors, or its authorized representatives.

NOTE: A person shall not seek diagnosis from a physical therapist or a physician for purposes of meeting the requirements of this section on more than 2 occasions within a 6-month period. If a person seeks diagnosis from a physical therapist and the results of the testing do not meet the eligibility requirements for a permit, the person may do either of the following:

- a. Within 30 days of obtaining the test results, seek another opinion from the same or a different physical therapist.
- b. After 180 days or more, seek another opinion from the same or a different physical therapist.

PHYSICAL THERAPIST / PHYSICIAN - DISABILITY CRITERIA AND REQUIRED TEST STANDARDS FOR SECTION III

Muscle weakness with a grade of fair or below will be used to determine if a person is eligible for a permit. Testing by a physical therapist shall use as a guideline the "Techniques of Manual Muscle Testing" by Daniels and Worthingham or other guidelines accepted by the American Medical Association.

Impaired range of motion shall be determined with goniometric measurements using the "American Medical Association Guide to Evaluation and Permanent Impairment Rating", or other guidelines accepted by the American Medical Association.

Peripheral nerve involvement shall be determined using the "American Medical Association Guide to Evaluation and Permanent Impairment Rating" or other guidelines accepted by the American Medical Association.

Unilateral hand weakness disability: In addition to manual muscle testing, a grip dynamometer, pinch grip, and lateral grip muscle measurements shall be used to compare dominant to non-dominant hand. A 5% deficit is standard acceptance for the non-dominant hand. Bilateral hand weakness or bilateral upper extremity weakness, or both, are subject to manual muscle testing only.

Coordination Assessment. Coordination is the ability to execute smooth, accurate, controlled movement. Incoordination or coordination deficit describes abnormal motor function characterized by awkward, extraneous, uneven, or inaccurate movements, caused by central nervous disorders, including, but not limited to, Parkinson's Disease, Cerebral Palsy, Hemiplegia, Hemiparesis, and closed head trauma, or by progressive neuromuscular diseases, such as Muscular Dystrophy, Multiple Sclerosis, and Amyotrophic Lateral Sclerosis. This test is to assess the ability of muscles or groups of muscles to work together to perform a task. **For safety considerations, this test shall eliminate severely impaired applicants from qualifying for a permit.**